ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

Vendor Name _____ Vendor Number _____

For The Period from _____ to _____

A. Type of Control

1. Voluntary Non-Profit
   Church_____
   Other(Specify)_____
   _____
   _____

2. Proprietary
   Individual_____
   Partnership_____
   Corporation_____
   Other(Specify)_____
   _____
   _____

3. Government
   State_____
   County_____
   City_____
   Other(Specify)_____
   _____
   _____

B. Statement of costs of services from Related Organizations

1. In the amount of costs to be reimbursed by the KMAP Program, are any costs included which are the result of transactions with a related organization?

   Yes_____ No_____ (If "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Costs incurred as the result of transactions with related organizations.

Schedule	Line #.	Item	Amount

D. Name & percent of direct or indirect ownership of the related organization.

Name of Owner	Name of Related Organization	Percent

E. Statement of Compensation of Owners

Name	Title & Function	Percent of Customary Work Week Devoted to Business	Partners % of Operating Profit or Loss	Corp. Off. % of Vendor's Stock Owned	Total Compensation

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

Vendor Name _____ Vendor Number

For The Period from _____ to _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

Name	Title	Percent of Customary Work Week Devoted to Business	Percent of Person Employed

G. Has the facility had a change of ownership in the past fiscal year? A change of ownership is defined as the transfer of the assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes____ No____

If yes, indicate the new owners and the percent owned. (If corporate owned, list individuals.)

Name	Percent Owned

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medical Assistance Annual Cost Report for the period ended _____, and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of _____, in accordance with applicable program directives, except as noted.

(Signed)_____
Officer or Administrator of Facility

_____
Title

ANNUAL COST REPORT
SCHEDULE B'
STATEMENT OF INCOME AND EXPENSES

VENDOR NAME _____ FYE _____

VENDOR NUMBER _____

1. Total Patient Revenues		$
2. Less: Allowances and discounts on patients' accounts		
3. Net Patient Revenues		$
4. Less: Total operating expenses		
5. Net income from services to patients		$
OTHER INCOME		
6a. Unrestricted contributions, donations, bequests, etc.	$	
6b. Restricted contributions, donations, bequests, etc.		
7a. Income from unrestricted investments		
7b. Income from restricted investments		
8. Vending machine commission		
9. Revenue from meals sold to employees and guests		
10. Revenue from sale of drugs, supplies, etc., sold to non-patients		
11. Revenue from telephone and telegraph service		
12. Revenue from rental of non-patient facilities		
13. Revenue from Beauty/Barber Shop		
14. Purchase discounts		
15. Other (specify)		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31. Total other income		$
32. Total of line 5 and line 31		$
OTHER EXPENSES (Specify)		
33.	$	
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		
49. Total other expenses		$
50. NET INCOME FOR THE PERIOD (line 32 less line 49)		$

ANNUAL COST REPORT
SCHEDULE C
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME _____ FYE _____

VENDOR NUMBER _____

ASSETS

		(1) Per Books	(2) Adjustments	(3) Balance
	Current Assets			
1.	Cash			
2.	Notes and Accounts Receivable			
3.	Other Receivables			
4.	Less: Allowance for Uncollectable Accounts	( )	( )	(
5.	Inventory			
6.	Prepaid Expenses			
7.	Investments			
8.	Other (Specify)			
	_____			
	_____			
	_____			
9.	*Total Current Assets*	$	$	$
	Fixed Assets			
10.	Land			
11.	Building and Leasehold Improvements			
12.	Less: Accumulated Depreciation	( )	( )	(
13.	Fixed Equipment			
14.	Less: Accumulated Depreciation	( )	( )	(
15.	Major Movable Equipment			
16.	Less: Accumulated Depreciation	( )	( )	(
17.	Motor Vehicles			
18.	Less: Accumulated Depreciation	( )	( )	(
19.	Minor Equipment			
20.	Less: Accumulated Depreciation	( )	( )	(
21.	*Total Fixed Assets*	$	$	$
	Other Assets			
22.	Investments			
23.	Lease Deposits			
24.	Due from Owners or Officers (Specify)			
	_____			
	_____			
	_____			
	_____			
	_____			
25.	Other (Specify)			
	_____			
	_____			
	_____			
26.	*Total Other Assets*	$	$	$
27.	Total Assets	$	$	$

ANNUAL COST REPORT
SCHEDULE C (cont.)
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME _____ FYE _____

VENDOR NUMBER _____

LIABILITIES

	Current Liabilities	(1) Per Books	(2) Adjustments	(3) Balance
28.	Accounts Payable			
29.	Notes Payable			
30.	Current Portion of Long Term Debt			
31.	Salaries and Fees Payable			
32.	Payroll Taxes Payable			
33.	Income Taxes Payable			
34.	Deferred Income Payable			
35.	Other (Specify)			
	_____			
	_____			
	_____			
36.	*Total Current Liabilities*	$	$	$
	Long Term Liabilities			
37.	Mortgage Payable			
38.	Notes Payable			
39.	*Total Long Term Liabilities*	$	$	$
40.	Total Liabilities	$	$	$

CAPITAL AND OWNERS' EQUITY

41.	Common Stock			
42.	Preferred Stock			
43.	Treasury Stock			
44.	Retained Earnings			
45.	Other (Specify)			
	_____			
	_____			
	_____			
46.	Total Capital and Owners' Equity	$	$	$
47.	Total Liabilities and Capital	$	$	$

ANNUAL COST REPORT
SCHEDULE C-1
BALANCE SHEET AND EQUITY CAPITAL ADJUSTMENTS

VENDOR NAME _____ FYE _____

VENDOR NUMBER _____

ITEM	EXPLANATION	AMOUNT	CLASSIFICATION ADJUSTED ACCOUNT	LIN
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
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43				
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46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56	TOTAL			

TN # 90-6
Supersedes
TN # None

Approval Date SEP 28 1990

Effective Date 10-1-90

ANNUAL COST REPORT -- SCHEDULE D-1 -- NURSING SERVICES COSTS

VENDOR NAME _____ VENDOR NUMBER _____ FYE _____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloc. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloc. of Costs
1	Director of Nursing Salary							
2	R.N. Salaries							
3	L.P.N. Salaries							
4	C.M.A. Salaries							
5	Aides Salaries							
6	Other Salaries_____							
7	Other Salaries_____							
8	Other Salaries_____							
9	*Subtotal-Salaries*							
10	Employee Benefits Reclassification							
11	Nursing Contracted Services							
12	Medical Records Salaries							
13	Medical Director Fees							
14	Pharmacy Consultant Fees							
15	Physician Services							
16	Nursing Education & Training							
17	Nursing Travel Expense							
18	Medical Supplies							
19	Adult Diapers & Underpads							
20	Nursing Equipment Rental							
21	Nursing Small Equipment Purchases							
22	Other Expense_____							
23	Other Expense_____							
24	Other Expense_____							
25	Other Expense_____							
26	Other Expense_____							
27	Other Expense_____							
28	Other Expense_____							
29	Other Expense_____							
30	Other Expense_____							
31	Other Expense_____							
32	Other Expense_____							
33	Other Expense_____							
34	*Total*							

TN # 90-6
Supersedes
TN # None

Approval Date SEP 28 1990

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ANNUAL COST REPORT --SCHEDULE D-2 -- OTHER CARE RELATED COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1) Care Related	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs
1	Activities Salaries							
2	Social Services Salaries							
3	Other Salaries_____							
4	Other Salaries_____							
5	Other Salaries_____							
6	*Subtotal-Salaries*							
7	Employee Benefits Reclassification							
8	Activities Supplies							
9	Social Services Supplies							
10	Training & Education Expense							
11	Travel Expense							
12	Other Expense_____							
13	Other Expense_____							
14	Other Expense_____							
15	Other Expense_____							
16	Other Expense_____							
17	Other Expense_____							
18	Other Expense_____							
19	Other Expense_____							
20	Other Expense_____							
21	Other Expense_____							
22	Other Expense_____							
23	Other Expense_____							
24	Other Expense_____							
25	Other Expense_____							
26	Other Expense_____							
27	Other Expense_____							
28	Other Expense_____							
29	Other Expense_____							
30	Other Expense_____							
31	Raw Food							
32	*Total*							

TN # 90-6
Supersedes
TN # None

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
Dietary								
1 Dietary Salaries								
2 Other Salaries_____								
3 Other Salaries_____								
4 Other Salaries_____								
5 *Subtotal-Salaries*								
6 Employee Benefits Reclassification								
7 Dietary Consultant Fees								
8 Dietary Supplies								
9 Equipment Rental								
10 Small Equipment Purchases								
11 Other Dietary Expense_____								
12 Other Dietary Expense_____								
13 Other Dietary Expense_____								
14 Other Dietary Expense_____								
15 Other Dietary Expense_____								
16 Other Dietary Expense_____								
17 Other Dietary Expense_____								
18 Other Dietary Expense_____								
19 Other Dietary Expense_____								
20 *Total Dietary Expense*								
Housekeeping & Plant Operation								
21 Housekeeping Salaries								
22 Plant Oper. & Maint. Salaries								
23 Other Salaries_____								
24 Other Salaries_____								
25 Other Salaries_____								
26 *Subtotal-Salaries*								
27 Employee Benefits Reclassification								
28 Housekeeping Supplies								
29 Plant Oper. & Maint. Supplies								
30 Equipment Rental								
31 Repairs & Maintenance-Building								

TN # 90-6
Supersedes
TN # None

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10-1-90

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
32 Repairs & Maintenance-Equipment								
33 Repairs & Maintenance-Grounds								
34 Small Equipment Purchases								
35 Gas								
36 Electricity								
37 Water & Sewage								
38 Garbage Pick-up								
39 Contracted Services								
40 Pest Control Services								
41 Property Taxes								
42 Insurance-Property, Plant & Equipment								
43 Other Hskg. & Plant Op._____								
44 Other Hskg. & Plant Op._____								
45 Other Hskg. & Plant Op._____								
46 Other Hskg. & Plant Op._____								
47 Other Hskg. & Plant Op._____								
48 Other Hskg. & Plant Op._____								
49 Other Hskg. & Plant Op._____								
50 Other Hskg. & Plant Op._____								
51 Other Hskg. & Plant Op._____								
52 Other Hskg. & Plant Op._____								
53 Other Hskg. & Plant Op._____								
54 Other Hskg. & Plant Op._____								
55 Other Hskg. & Plant Op._____								
56 *Total Housekeeping & Plant Oper.*								
Laundry								
57 Laundry Salaries								
58 Other Salaries_____								
59 Other Salaries_____								
60 Other Salaries_____								
61 *Subtotal-Salaries*								
62 Employee Benefits Reclassification								
63 Laundry Supplies								
64 Linens & Bedding								